

**FAIRFAX COUNTY HEALTH DEPARTMENT  
INTERNATIONAL TRAVEL CLINIC**

NAME: \_\_\_\_\_ AGE: \_\_\_\_\_ TODAY'S DATE: \_\_\_\_\_

LAST, FIRST

LMP: \_\_\_\_\_

DATE OF DEPARTURE: \_\_\_\_\_

HOW LONG WILL YOU BE GONE? \_\_\_\_\_

REASON FOR TRIP: TOURIST: ☐ BUSINESS: ☐ OTHER: ☐

DO YOU PLAN TO TRAVEL OUTSIDE OF MAJOR CITIES? \_\_\_\_\_

ITINERARY (List Countries to be visited in order): \_\_\_\_\_

\_\_\_\_\_

**DO NOT WRITE BELOW THIS LINE**

**VACCINATION PLAN**

This does not take the place of an Official Record of Vaccines

DATE	DISEASE/ VACCINE	DURATION OF PROTECTION		DATE	DISEASE/ VACCINE	DURATION OF PROTECTION
	<b>Tetanus Diphtheria (Td)</b>	<b>10 years</b>			<b>Meningococcal Meningitis</b>	<b>3 years</b>
	<b>Measles, Mumps, Rubella (MMR) <i>Series of 2</i></b>	<b>Lifetime</b>			<b>Hepatitis A (Havrix) <i>Series of 2</i></b>	<b>Lifetime</b>
	<b>Polio: OPV or IPV</b>	<b>Lifetime, after booster</b>			<b>Immune/Gamma Globulin <i>For prevention of Hepatitis A</i></b>	<b>3 months</b>
	<b>Yellow Fever</b>	<b>10 years</b>			<b>Hepatitis B <i>Series of 3</i></b>	<b>Lifetime</b>
	<b>Typhoid: Oral <i>(Must be at least 6 years old)</i></b>	<b>5 years</b>			<b>Japanese Encephalitis <i>Series of 3</i></b>	<b>Unknown 2 or 3 years</b>
	<b>Typhoid: Injectable ViCPS <i>(Must be at least 2 years old)</i></b>	<b>2 years</b>			<b>Flu</b>	<b>1 year</b>
	<b>Malaria</b>	<b>Per trip</b>			<b>Rabies <i>Series of 3</i></b>	<b>Booster every 2 years</b>

RETURN DATE	VACCINE NEEDED